



# A Guide to Your Benefits



BlueCross BlueShield  
of Delaware  
[bcbsde.com](http://bcbsde.com)



**STATE OF DELAWARE  
GROUP SPECIAL MEDICFILL®**

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## **WELCOME**

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This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Blue Cross Blue Shield of Delaware (BCBSD).

This booklet summarizes benefits of the Group Special Medicfill Health Care Plan that helps fill many of the gaps in Medicare coverage. For your convenience, technical terms have been defined in the *Definitions* section at the back of the booklet.

This booklet is not a contract. It is designed to provide a summary of benefits for easy reference. The benefits and the terms and conditions of your Medicfill Health Care Plan are in an Account Contract on file with the Statewide Benefits Office, OMB. The Account Contract is the final determination of the benefits and rules of your plan.

This booklet describes the Medicfill Health Care Plan in effect as of July 1, 2012 and replaces all previous booklets.

**KEEP THIS BOOKLET HANDY FOR REFERENCE WHEN YOU NEED IT.**

## **WHEN YOU HAVE QUESTIONS OR COMMENTS**

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BCBSD welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about BCBSD's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan;
- reporting a lost or stolen ID card;
- ordering a new ID card;
- letting us know when you have a new address; and
- asking about a claim
- getting language assistance.

You may call, write, email or visit with your questions.

### **To Reach Us By Phone:**

Local Calls: 302.429.0260

Long Distance Calls: 800.633.2563

To talk to a Customer Service Representative, call 8:30 AM to 7:00 PM Eastern Standard Time (EST), Monday through Friday.

You can also get the following information when you call outside the Customer Service Representative hours. Our automated system (VRU) is available Monday through Friday, 24 hours a day, and Saturday until midnight EST for:

- enrollment information;
- claims status; and
- ID card requests.

### **To Reach Us By Letter:**

Write to:

Customer Service  
Blue Cross Blue Shield of Delaware  
P. O. Box 1991  
Wilmington, DE 19899-1991

### **To Reach Us In Person:**

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call BCBSD's Customer Service Department.

### **To Reach Us On The Internet:**

Internet Address: **[bcbsde.com](http://bcbsde.com)**

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## **SPECIAL MEDICFILL HEALTH CARE PLAN BENEFIT HIGHLIGHTS**

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The following highlights your Special Medicfill benefits and how these benefits supplement your Medicare Coverage.

**THESE BENEFIT HIGHLIGHTS ONLY BRIEFLY DESCRIBE THE BENEFITS AVAILABLE TO YOU FROM MEDICARE. FOR A COMPLETE DESCRIPTION OF YOUR MEDICAL BENEFITS UNDER MEDICARE, AND ANY LIMITATIONS ON THOSE BENEFITS, CONSULT MEDICARE PUBLICATIONS OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AT [CMS.HHS.GOV](https://www.cms.hhs.gov).**

This booklet describes the benefits, terms and conditions of your Special Medicfill Health Care Plan. This Health Care Plan is designed to supplement Medicare. Unless otherwise indicated, we will pay the benefits described in this booklet only after Medicare pays its full amount.

## PREVENTIVE BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
<b>Note:</b> The following is a list of preventive services provided by Medicare that are supplemented by this plan. Some services are subject to coinsurance only, while others are subject to the Part B deductible and coinsurance. Medicare also pays for other preventive services (for example, flu shots and diabetes and cardiovascular screenings) that are not subject to either the Part B deductible or coinsurance, but are not listed below. See the <i>Medicare and You</i> information manual for information about these services.			
‘Welcome to Medicare’ Physical Exam (covered only within the first six months of your Part-B enrollment)	Medicare pays 100% of Medicare Eligible expenses with no Part B deductible for a one-time review of your health, including certain screenings and shots, and if needed, referrals for other care.	Nothing.	You pay nothing.
Yearly Wellness Visits	Medicare pays 100% of the Medicare Eligible expenses, with no Part B deductible requirement	Nothing.	You pay nothing.
Abdominal Aortic Aneurysm Screening	Medicare pays 100% of the Medicare Eligible expenses, with no Part B deductible requirement, for a one-time screening ultrasound if you are at risk, only if you are referred for the screening as a result of the ‘Welcome to Medicare’ Physical Exam.	Nothing.	You pay nothing.
Annual Routine Mammogram	Medicare pays 100% of Medicare Eligible expenses, with no Part B deductible requirement, for annual mammograms for women age 40 and over.	Nothing.	You pay nothing.

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Pap Smear	Medicare pays 100% of Medicare Eligible expenses, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk.	When Pap smears for cancer screening are covered by Medicare, this plan pays nothing. When not covered by Medicare, this plan will pay 100% of our allowable charge for a Pap Smear every 12 months.	You pay nothing.
Pap collection, Pelvic Exams and Breast Exams	Medicare pays 100% of Medicare Eligible expenses, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk.	Nothing.	You pay nothing.
Glaucoma Tests	Medicare pays 80% of Medicare Eligible expenses after the Part B deductible for annual glaucoma tests for persons who are at high risk for glaucoma, including diabetics and those with a family history of glaucoma.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	You pay nothing.
Colorectal Cancer Screening	<p>Medicare pays 100% of Medicare Eligible expenses with no Part B deductible requirement for:</p> <ul style="list-style-type: none"> <li>■ fecal occult blood test</li> <li>■ flexible sigmoidoscopy every 48 months for covered persons age 50 and over who are at average risk; and</li> <li>■ colonoscopy every 2 years for those covered persons who are at high risk, and</li> </ul> <p>Medicare pays 80% of</p>	When barium enema tests are covered by Medicare, this plan covers the Medicare Part B deductible and 20% coinsurance. Otherwise this plan pays nothing.	You pay nothing.



<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
	<p>Medicare Eligible expenses after the Part B deductible requirement for:</p> <ul style="list-style-type: none"> <li>■ barium enema – Once every 48 months if age 50 or older when used instead of a sigmoidoscopy or colonoscopy</li> </ul>		
Bone Mass Measurement	Medicare pays 100% of Medicare Eligible expenses with no Part B deductible for bone mass measurement tests for persons who are at high risk for broken bones.	Nothing.	You pay nothing.

## INPATIENT HOSPITAL & OTHER FACILITY BENEFITS

<b>Benefit:</b>		<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Inpatient Days in Acute Hospitals; Semi-Private Room and Ancillary Services (for covered expenses each benefit period)	Days 1-60	Medicare pays all but the Medicare Part A deductible.	This plan covers the Medicare Part A deductible.	You pay nothing.
	Days 61-90	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan covers a specified dollar amount of coinsurance.	You pay nothing.
	Days 91-120	Medicare pays nothing. (There are 60 Lifetime Reserve Days* with all but the daily coinsurance amount covered. These days may be used at the patient's discretion.)	This plan covers inpatient care for days 91 through 120 in a general hospital except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.
	Days 121-365	Medicare pays nothing.	This plan covers inpatient care for days 121 through 365, except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.

\*Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.

## INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

<b>Benefit:</b>		<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Hospice		Medicare pays 100% of eligible expenses, subject to Medicare criteria.  Medicare also covers 95% of the cost of up to 5 days of inpatient respite care.	When Medicare standards are met, and Medicare pays, this plan covers the 5% coinsurance not paid by Medicare for up to 5 days of inpatient respite care.	You pay nothing.
Treatment for Mental or Nervous Disorders (in a Psychiatric Hospital)		Benefits are limited to 190 days for your lifetime. Medicare covers all but the Medicare Part A deductible and the specified coinsurance for days 61-120	This plan covers the Medicare Part A deductible and the specified dollar amount of coinsurance for up to the 190 lifetime days approved by Medicare.	You pay nothing while Medicare is paying. You pay all charges thereafter.
Inpatient Dental Surgery		Medicare covers hospital services for surgery related to the jaw or reduction of any fracture of the jaw or facial bone.	This plan covers the Medicare Part A deductible and specified dollar amount of coinsurance when Medicare standards are met.	You pay nothing.
Services in a Medicare Approved Skilled Nursing Facility	Days 1-20	Medicare pays 100% of eligible expenses.	This plan pays nothing.	You pay nothing.
	Days 21-100	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan pays a specified dollar amount of coinsurance per day.	You pay nothing
Coverage Outside of the United States		Generally, Medicare does not pay for services provided outside the U.S.	When Medicare standards are met, and Medicare pays, this plan covers the Part A deductible and coinsurance for the first 90 days and then 100% of the allowable charge for days 91-120.  If the admission does not qualify for payment under Medicare, but if it	You pay nothing.  You pay nothing for the first 120 days if the hospital confinement is

meets Medicare  
criteria for an inpatient  
admission within the  
United States, we will  
pay for services as  
defined by Medicare  
Law for 120 days of  
inpatient care.

approved for payment  
by BCBSD. You pay  
all charges thereafter.

## OUTPATIENT HOSPITAL BENEFITS

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
<ul style="list-style-type: none"> <li>■ Anesthesia</li> <li>■ Clinical Services</li> <li>■ Emergency Accident</li> <li>■ Dialysis</li> <li>■ Injections (except most routine immunizations)</li> <li>■ Machine Testing</li> <li>■ Medical Emergency</li> <li>■ Minor Surgery</li> <li>■ Physical Therapy</li> <li>■ Radiation Therapy</li> <li>■ Imaging Services</li> </ul>	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges**.	You pay nothing.
Clinical Laboratory Services	Covered at 100% of the Reasonable Charge**	There is no coverage under this plan Clinical Laboratory Services.	You pay charges, if any, for services not covered by Medicare.
Home Health Visits	Covered at 100% of the Reasonable Charge**, subject to Medicare criteria.	There is no coverage under this plan for Home Health Visits.	You pay charges, if any, for services not covered by Medicare.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers hospital benefits equivalent to Medicare hospital benefits in the U.S., including the payment of the deductible and coinsurance amounts.	You pay nothing.
		When Medicare does not pay, payment will be made for those covered services as defined by Medicare. Payment must be approved by BCBSD	You pay nothing if the care is approved for payment by BCBSD.

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

## SURGICAL-MEDICAL BENEFITS

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
<ul style="list-style-type: none"> <li>■ Ambulance</li> <li>■ Anesthesia</li> <li>■ Appliances</li> <li>■ Chiropractic Services (subject to Medicare criteria)</li> <li>■ Clinic Visits</li> <li>■ Durable Medical Equipment</li> <li>■ Home &amp; Office Visits</li> <li>■ Imaging Services</li> <li>■ Inpatient Consultants</li> <li>■ Inpatient Medical Visits</li> <li>■ Inpatient Professional Services</li> <li>■ Inpatient Skilled Nursing Facility Visits</li> <li>■ Laboratory</li> <li>■ Machine Testing</li> <li>■ Medical Emergency Care</li> <li>■ Physical Therapy</li> <li>■ Radiation Therapy</li> <li>■ Surgery</li> </ul>	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	You pay nothing.

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

## SURGICAL-MEDICAL BENEFITS (CON'T)

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Outpatient Treatment for Mental and Nervous Disorders	Medicare covers 60% (2013: 70%; 2014: 80%) of the Reasonable Charges** accepted by Medicare after the Medicare Part B deductible. If services are rendered in a partial hospitalization program or in the outpatient department of a hospital, Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 40% (2013: 30%; 2014: 20%) or 20% of the Reasonable Charges**, whichever is applicable.	You pay nothing.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.  When Medicare does not pay, benefits are covered as are covered under this contract at 20% of the BCBSD traditional Resource Based Relative Value Scale (RBRVS) allowable.	You pay nothing.  You pay all charges over 20% of the BCBSD traditional Resource Based Relative Value Scale (RBRVS) allowable.

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

## OTHER COVERED BENEFITS

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Outpatient Prescription Drugs	Medicare Part B covers 80% of the reasonable charges for a <b>very limited number of drugs</b> (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See <b>medicare.gov</b> for more information.	This program pays the 20% coinsurance for these drugs.	You pay nothing.
Private Duty Nursing	No coverage under Medicare.	This plan covers the services of a Registered Professional Nurse (RN) for care provided in an acute care facility at 80% of BCBSD's allowable charge, up to a maximum of 240 hours during any 12-month period. If an RN is not available, at our discretion, benefits may be provided for the services of a Licensed Practice Nurse (LPN).	You pay 20% of the allowable charges. You also pay any charges incurred after the 240-hour maximum has been met.



## HUMAN ORGAN TRANSPLANT BENEFIT

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Human organ transplants	Benefits are provided on the same basis and at the same level as Inpatient Hospital Benefits, Outpatient Hospital Benefits, and Physician Services, subject to the Medicare Part A and Part B deductibles and coinsurance.	When Medicare pays for an organ transplant, this plan provides benefits on the same basis and at the same level as other Special Medicfill benefits.  See the benefit description on page 15 for more information about organ transplants, including benefit limits.	You pay any charges not covered by Medicare or Special Medicfill, and any charges over the maximum limits of this plan.

## **PREVENTIVE CARE**

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Benefits for the following preventive care and wellness programs are paid at 100% of BCBSD's allowable charge. If Medicare pays any portion, BCBSD will pay the balance up to 100% of the allowable charge.

### **PREVENTIVE CARE**

BCBSD promotes preventive care to help you stay well. We administer these benefits according to the BCBSD Preventive Health Guidelines materials. These materials contain details of when we pay for Preventive Care. They are available from BCBSD, or online at **bcbsd.com**. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

**Please note: BCBSD has the right to change these benefits at any time.**

### **EXAMINATIONS**

Benefits are provided for:

- routine physical exam
- routine GYN exam and Pap smear

### **TESTS AND SCREENINGS**

Some examples of covered routine tests and screenings are:

- hemoglobin test
- cholesterol test
- blood sugar test
- blood antigen test for prostate cancer
- blood occult
- lead screening test
- mammogram
- flexible sigmoidoscopy

### **ROUTINE IMMUNIZATIONS**

Some examples of covered routine immunizations are:

- Hepatitis A
- Hepatitis B
- Varicella (chickenpox) vaccine
- DTaP (diphtheria, pertussis, tetanus)
- Td (Tetanus)
- MMR (measles, mumps, rubella)
- IPV (polio)
- Hib (haemophilus influenza)
- Influenza
- Pneumococcal

Immunizations considered by BCBSD to be experimental in nature are not covered.

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## **HOSPITAL AND OTHER FACILITY BENEFITS**

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### **INPATIENT HOSPITAL SERVICES**

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, we will pay the Medicare Part A deductible.
- For days 61 through 90, we will pay the specified daily coinsurance.
- For days 91 through 120, we will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, we will pay the coinsurance amount.
- For days 121 through 365, we will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. We will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, we will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

### **SKILLED NURSING FACILITY**

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, we will pay the applicable daily coinsurance for days 21 through 100.

### **HOSPICE**

To qualify for hospice care, your doctor must certify that you're terminally ill and have 6 months or less to live. Coverage includes drugs for pain relief and symptom management, nursing, some durable medical equipment and spiritual and grief counseling.

A Medicare-approved hospice usually gives hospice care in your home or other facility where you live such as a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home.

Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care.

You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

This plan will pay 5% of the Medicare-approved amount for inpatient respite care.

## **SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES**

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, we will pay the Part A deductible and the daily coinsurance for the first 90 days. We will then pay 100% of the allowable charges for days 91-120.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, we will pay for covered services as defined by Medicare law at 100% of the allowable charge for 120 days of inpatient care.

## **OUTPATIENT HOSPITAL SERVICES**

We pay the Medicare Part B deductible and then we pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a free-standing facility and Medicare pays, then we will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- Emergency Treatment that is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- Minor Surgery.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Diagnostic imaging services, laboratory and machine testing.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Hemodialysis.
- Clinical Services.
- Injections (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).
- Coverage Outside the United States-In those cases where Medicare will pay, we will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, we will pay for those covered services as defined by Medicare at 100% of the allowable charge.

## **SURGICAL-MEDICAL BENEFITS**

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We pay the Medicare Part B deductible, and then we pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

### **COVERED SERVICES**

Covered services are as defined by Medicare and include:

- Appliances and Durable Medical Equipment.
- Ambulance Services.
- Home and Office Visits.
- Inpatient Hospital Medical Visits.
- Surgery.
- Imaging Services.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Inpatient Consultations.
- Inpatient Skilled Nursing Facility medical visits.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Laboratory and machine testing.
- Injections (not including routine immunizations – See *Preventive Benefits*).
- Clinic Visits.
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.

### **OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS**

We will pay the Medicare Part B deductible and then 40% (30% in 2013 and 20% in 2014) of the reasonable charge for outpatient treatment of mental and nervous disorders. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, we will pay 20% of the reasonable charge.

### **SERVICES OUTSIDE THE UNITED STATES**

- For services outside of the United States, in those cases where Medicare will pay, we will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of Medicare's Resource-Based Relative Value Scale (RBRVS).

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## OTHER COVERED BENEFITS

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The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

### OUTPATIENT PRESCRIPTION DRUGS

Medicare Part B covers 80% of the reasonable charges for a **very limited number of drugs** (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See **medicare.gov** for more information.

### PRIVATE DUTY NURSING - INPATIENT

When you are an inpatient in an acute hospital ('hospital' is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of BCBSD's allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of BCBSD's allowable charge.

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## HUMAN ORGAN TRANSPLANT BENEFIT

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The benefits listed in this section are only available for services related to medically necessary human organ transplants. If Medicare covers these services, services related to kidney, cornea and bone marrow transplants are covered on the same basis and at the same level as other surgical benefits under this benefit plan and are not subject to the benefits and limitations of this section.

Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

### Benefits Available

Subject to all the terms and conditions of this benefit plan, when a human organ transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.
- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure. The maximum amount payable for this benefit is \$10,000 for each cadaveric organ and up to \$45,000 for each organ procured from a living donor (including harvesting)..
- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.
- If Medicare covers these services, reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of \$150, by those individuals accompanying the recipient.

### Benefit Limitations

- The benefits for transportation, lodging and meal expenses are subject to an aggregate maximum of \$10,000 per covered transplant procedure. All covered transportation costs, lodging and meal expenses incurred are paid at the same level as outpatient doctor's visits.
- The organ transplant benefits specified in this section are available only during the applicable benefit period. For purposes of this Human Organ Transplant Benefit, the Benefit Period shall mean 5 days immediately prior to and one year immediately following a covered Organ Transplant Procedure.
- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.

## **EXCLUSIONS**

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The following services and other items are excluded from your coverage under this Medicfill plan:

- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Unless otherwise specified in this health care plan, charges for covered services that are over the Medicare reasonable charge for that service.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services or supplies available, in whole or in part under the laws of the United States (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Services rendered by any member of your immediate family or any person living with you. For purpose of this paragraph only, family includes parents, spouses, siblings, and natural or adopted children of whatever age.
- Services for which no charge would normally be made in the absence of insurance.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
- Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
- Hearing aids and the examination, prescription or fitting of same,
- All procedures for refractive correction.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Routine foot care.
- Blood or blood donor services, including blood components.
- Supplies or services for cosmetic purposes, including routine treatment of acne and treatment for hair loss restoration.
- Unless specified otherwise, services for routine physical examinations or other examinations or treatments including, but not limited to, those procured by you to satisfy requirements of any third



party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court, or legal representative, unless specified otherwise. School, camp, and pre-marital physicals are also excluded.

- Services not directly related to or medically necessary for the diagnosis or treatment of an illness or injury. Medical necessity is defined by us as: medically necessary services or supplies provided by a hospital, doctor or other provider to identify or treat an illness or injury and which, as determined by us are:
  - Consistent with the symptom or diagnosis and treatment of a condition, disease or injury;
  - Appropriate with regard to standards of accepted professional practice;
  - Not solely for your convenience, your doctor's convenience or any other provider's convenience; and,
  - The most appropriate supply or level of service which can safely be provided to you. When applied to an inpatient it further means that your medical symptoms or condition require that the service or supplies cannot be safely provided to you as an outpatient.

We may base payment upon Medicare's determination of medical necessity.

- Computerized gait analysis or electrodiagnostic testing.
- Services and supplies for or related to visual therapy or orthoptics.
- Services by a medical department maintained by your employer.
- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.
- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.
- Services, supplies, or drugs obtained in violation of applicable law.
- Prescription drugs (except for the limited number of drugs covered by Medicare Part B) for use outside the hospital, even if your doctor writes you a prescription. Prescriptions are covered either through the prescription vendor contracted with the State of Delaware, or through the Medicare Part D program (but not through both). Contact your Pension Office for more information

## VALUE ADDED FEATURES

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BCBSD offers Value Added Features. They are described below.

Value Added Features are administered only as specified in the BCBSD Value Added Features materials.

**Please note: BCBSD has the right to change or discontinue these programs at any time.**

### EYEWEAR DISCOUNTS

*On behalf of BCBSD, your eyewear discount program is administered by Davis Vision, an independent managed vision care company.*

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit **[www.davisvision.com](http://www.davisvision.com)**.

### DISCOUNT PROGRAMS

Savings on a variety of product and services are available to BCBSD members, including:

- Fitness clubs
- Alternative health services (i.e., acupuncture, chiropractic care)
- Laser vision corrective surgery
- Fitness gear
- Weight loss programs and healthy eating options
- Hearing aids

For a full listing of our discounts go to [bcbsde.com](http://bcbsde.com) or call us at 302.429.0260 / 800.633.2563.

## HOW TO CLAIM BENEFITS

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**Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.**

### HOW TO CLAIM HOSPITAL AND SURGICAL-MEDICAL BENEFITS

Since this program supplements Medicare benefits, claims for benefits must first be submitted for coverage through Medicare.

*A Request for Medicare Payment Form*, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All Social Security offices, and most doctors' offices, have copies of this form. Instructions on how to fill it out are on the back of the form.

When Medicare has paid for the services of doctors and suppliers that are covered by your medical insurance, you will receive an *Explanation of Benefits* notice explaining what coverage has been provided.

#### INSIDE DELAWARE

When you receive care inside Delaware, put your Blue Cross Blue Shield Identification Number on your *Request for Medicare Payment Form*. Payment will be made to the provider of services.

#### OUTSIDE DELAWARE

##### Medicare Part A Hospital Services

If you are hospitalized outside of Delaware, supply the hospital with your Blue Cross Blue Shield Identification Number. The hospital or Skilled Nursing Facility that provides you service will submit a Medicare Claim Form to the Medicare Part A Intermediary in the area where you receive care. Payment will be made to the provider of services.

##### Medicare Part B Doctor's Services

If you receive surgical-medical care outside of Delaware, supply the doctor or provider with your Blue Cross Blue Shield Identification Number. The doctor or provider will submit the claim to Medicare in the area where you receive care. Payment will be made to the provider of services.

#### OUTSIDE THE UNITED STATES

##### For claims incurred while on a cruise ship:

Send a copy of the *Explanation of Benefits* form you received from Medicare to:

Blue Cross Blue Shield of Delaware  
P.O. Box 8831  
Wilmington, DE 19899-8831

BCBSD will pay you directly for benefits in accordance with this health care plan.

### **For all other international claims:**

Use the BlueCard Worldwide® International Claim Form available at [bcbsde.com](http://bcbsde.com), and send the form to:

BlueCard Worldwide Service Center  
P.O. Box 72017  
Richmond, VA 23255-2017 USA

## **HOW TO CLAIM OTHER COVERED BENEFITS**

### **PRIVATE DUTY NURSING**

For private duty nursing inpatient benefits, please submit the following information to us:

- Name of the hospital.
- Date of admission to the hospital.
- Date of discharge from the hospital.
- Diagnosis.
- Attending physician's signature.
- Either a completed Claim Form CL-65, which may be obtained in any Delaware hospital, or the nurse's receipt showing the nurse's registration number. If the nurse's receipt is submitted without Form CL-65, you must also include the signed authorization of the attending physician.
- Your name, address, and Blue Cross Blue Shield Identification Number (referred to in some cases as 'contract' or 'certificate' Identification Number).

## **GRIEVANCE AND APPEALS - HOW TO APPEAL A CLAIM DECISION**

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

### **BCBSD'S APPEAL PROCESS**

- To appeal a BCBSD decision, you or your representative must contact Customer Service **within 180 days** from the date you received the decision. You may call us or you may use the BCBSD *Appeal Form*, available at [bcbsde.com/downloads/AppealForm.pdf](http://bcbsde.com/downloads/AppealForm.pdf). There is no cost to appeal, and BCBSD will provide copies of records relevant to your claim upon written request. Members should use the *Designation of Personal Representative for Appeal Purposes* form (available at [bcbsde.com/downloads/PersonalRepDesignationAppeal.pdf](http://bcbsde.com/downloads/PersonalRepDesignationAppeal.pdf)) to designate a personal representative for purposes of an appeal.
- Please explain why you believe the decision was wrong and provide any additional relevant information. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.
- **Pre-service decision:** For appeals relating to a service you have not received (BCBSD denied authorization and you have not received the service or treatment), you will be notified of the appeal decision within 30 days of your request. You may request an **expedited** appeal for coverage relating to urgent care. We will make an expedited appeal decision and notify you and your provider within 72 hours of your request.

- **Post-service decision:** For appeals relating to a service you have already received, you will be notified of the decision within 30 to 60 days of your request for an appeal.

### **AFTER THE BCBSD APPEAL**

- If you have appealed a decision involving medical judgment, experimental or investigational care and are not satisfied with the outcome, you are eligible for an independent review. You must contact BCBSD Customer Service Department in writing within 60 days of the date you received the appeal decision. Please include the appeal decision letter and all pertinent information that supports your request for review. BCBSD will arrange for a review by a medical provider who practices in the same or similar specialty at issue and who has not been involved in the initial decision or the appeal. There is no cost to you for this independent review. You will receive a written decision within 45 days.
- An expedited review is available if your physician certifies that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3 to 5 calendar days after receipt by BCBSD.
- If you request, BCBSD will provide copies of all records relevant to the BCBSD appeal decision.

### **ADDITIONAL LEVELS OF APPEALS**

For information on additional levels of appeal availability, please see <http://ben.omb.delaware.gov/medical/bcbs/> or telephone the State of Delaware's Benefits Office at 800.489.8933 or 302.739.8331.

If you would like more information, please contact BCBSD's Customer Service Appeals Team by one of the methods below.

#### **Internet:**

Visit our internet Customer Service Center at **bcbsde.com**.

#### **Telephone:**

302.429.0260 northern Delaware  
800.633.2563 all other locations  
302.421.3411 for the hearing impaired

#### **Mail:**

Blue Cross Blue Shield of Delaware  
PO Box 8832  
Wilmington, DE 19899-8832

### **IMPORTANT NOTE**

PLEASE READ A *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, PROVIDED BY THE FEDERAL GOVERNMENT'S CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) TO FIND OUT WHAT BENEFITS YOU CAN RECEIVE FROM THE MEDICARE PROGRAM.

## COORDINATION OF BENEFITS

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We reserve the right to coordinate available benefits for you so that duplication of payment of the same benefits will not occur and so that all parties having responsibility for payment for covered services perform in accordance with their benefit plan obligations. If you are entitled to benefits under any other plan as defined herein, to which you are a party or beneficiary, the amount of benefits payable under this plan and any other plan will be coordinated so that the aggregate amount paid will not exceed one hundred percent of the Allowable Expenses.

### DEFINITIONS

For the purpose of interpretation of this provision, the following definitions will apply:

*Allowable Expenses* means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more health benefit plans covering the individual for whom the claim is made.

*Coordination of Benefits Provision* means any provision of any plan that establishes the order in which plans pay benefits when an individual is insured under two or more plans.

*Other Plan* means any arrangement providing health care benefits or services, including but not limited to benefits or services through:

- Any form of health or other insurance, including nonprofit health service, or any other form of prepayment of insurance coverage including individual, group, blanket, franchise, fraternal, no-fault insurance or personal injury protection coverage;
- Any health maintenance organization or similar coverage;
- Coverage under any labor management trustees plan, union welfare plan, or employee benefit organization plan;
- Coverage under any governmental or tax supported program; or
- Coverage required by statute to be offered to or procured potentially by you whether or not you have the option of declining such coverage or of purchasing such coverage subject to mandatory or optional deductibles, including but not limited to personal injury protection coverage, no-fault coverage or similar provisions of state or other statutes.

*Primary Plan* means the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

*Secondary Plan* means the plan under which benefits are determined after those of the other plan. Benefits under a secondary plan may be reduced because of the other plan's benefits.

### ORDER OF BENEFITS DETERMINATION

The primary and secondary plan responsibility is determined according to the following rules as they apply to your Medicaid health care plan:

- A plan with no provision for coordination of benefits is primary over a plan that contains such provision.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.

- A plan that covers you as an active employee (or as that employee's dependent) is primary over a plan that covers you as a laid off or retired employee (or that employee's dependent).
- If two or more plans cover a dependent child of parents not divorced or separated, the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered one parent longer is primary.
- If the other plan's Coordination of Benefits provision determines primary or secondary plan responsibility based upon the parent's gender rather than upon the parent's birthday, the gender rule will control. As a result, the plan covering the dependent child of the male parent will be primary.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with the custody of the child; and
  - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the organization providing benefits has actual knowledge of the decree, the plan of that parent is primary.

- If the above rules do not establish which plan is primary, the plan that has covered the individual for the longer time period is primary.
- When there are two or more secondary plans, this order of benefit determination will be repeated until this plan's responsibility for benefits has been determined.

## **EFFECT ON BENEFITS**

- When this plan is primary, the benefits of the secondary plan will be ignored for the purpose of determining the benefits under this plan.
- When this plan is secondary, we will coordinate payments with those of the other plan(s) so that payments made by both (or all) plans will not exceed Allowable Expenses for covered services. In no event will we pay more than would have been paid had there been no other plan.

## **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

To determine the applicability of and to implement the terms of this provision, we may release to or obtain from any organization or individual any information deemed necessary.

You, personally, are obligated to provide information necessary to implement this provision. If you refuse to cooperate with us in providing necessary information or in securing payment, then coverage under this plan for that incident is null and void and we may, at our discretion, terminate the plan and take any other action necessary to protect our rights hereunder.

## **FACILITY OF PAYMENT**

When this plan is determined to be primary but payment was made under another plan, we have the right to reimburse the organization making such payments the amount that we determine is our liability in accordance with this provision. By making such payment, we will have satisfied the obligation under this plan.

## **RIGHT OF RECOVERY**

When we make payments that exceed the maximum amount of covered benefits that we must pay under the coordination of benefits rules, we have the right to recover the excess from any one of the following:

- Any person to or for whom such payments were made;
- Any insurance companies;
- Other organizations; or
- You.



## ELIGIBILITY INFORMATION

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### WHO IS ELIGIBLE

This Health Care Plan is made available through the State of Delaware who elected to provide Medicare supplementary coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have permanent kidney failure.

**You must be enrolled in Part A and Part B of the Medicare program.** You must also continue to be covered under both Part A and Part B to keep coverage in this plan.

### WHEN YOUR COVERAGE ENDS

#### DEATH

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

#### LOSS OF BENEFITS

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Also, persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

Contact your Pension Office for information regarding other coverage that may be available.

#### STATE DROPS COVERAGE

Your coverage (and your dependents coverage) ends on the date on which the State's contract with us for the provision of benefits ends.

#### BENEFITS AFTER YOUR COVERAGE ENDS

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because your employer dropped coverage with us, we will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because your employer dropped coverage, all health care benefits under this health care plan terminate on the date your group coverage terminates.

## **IF GROUP COVERAGE ENDS**

If your group coverage ends, you may apply directly to us for conversion to a contract under which you are billed personally (a 'direct-billed' contract) at the then current premium rate. You must apply within 31 days after your coverage under the group contract ends. You have this conversion right if:

- You have left your employer; or
- You are the ex-spouse of an employee; or
- You are the surviving spouse of a deceased employee; or
- You no longer meet the dependent child requirements on age, marital status, or financial support.

The direct-billed contract offered may provide fewer benefits and/or a lower benefit payment level than what you were eligible to receive under group coverage.

If another health insurance program is available where you are employed or in an organization with which you are affiliated, you and/or your dependents are not entitled to a group conversion direct-billed contract under this provision, regardless of whether the other health insurance program contains a preexisting condition limitation or the application is denied.

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## **GENERAL CONDITIONS**

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### **MEDICARE AMENDMENTS**

If there are changes to the Medicare Law or any other applicable law that either increase or decrease the amount of benefits or provide services not previously covered, benefits under this plan will be adjusted accordingly.

### **RELEASING NECESSARY INFORMATION**

Hospitals, doctors, pharmacies and other providers have information we need to determine your eligibility for both enrollment and benefits under this plan. By applying for coverage you agree to let any doctor, hospital, pharmacy or provider give us and our agents all the medical information we may need. This may include the diagnosis and history of any illness, disease, condition or symptom you have had, or for which coverage is sought; or other information. We will keep this information confidential to the extent permitted by law. However, by applying for coverage you authorize us to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board, utilization review organization and/or to any other insurance carrier or administrator or health maintenance organization for purposes of administration of this health benefits plan. If such information relates to fraud or other misrepresentation, we may disclose it to legal authorities or use it in legal proceedings. We reserve the right to charge a fee for the reproduction of claims records requested from us.

### **TIME LIMITS**

Requests for benefits must be received by us within 2 years from the date you received the service.

### **DENIAL OF LIABILITY**

We are not responsible for the quality of care received from any institution or individual. Your coverage does not give you any claim, right or cause of action against us based on an act of omission or commission of a hospital, nursing home, doctor or other provider of care or service.

### **RECEIPT OF BENEFITS**

In order for you to receive benefits, you must identify yourself as our customer as soon as possible. When you receive services, you must show the current membership card.

### **DUPLICATE COVERAGE**

If you have two or more benefit plans through Blue Cross Blue Shield corporations, benefits will be coordinated.

### **PAYMENT OF BENEFITS**

If your doctor accepts Medicare assignment, payment will be made directly to the doctor. He/she cannot bill you for any balance over the Medicare reasonable charge. However, if your doctor does not accept Medicare assignment and you have not assigned benefits under this plan to your doctor in accordance with Medicare program requirements, payment will be made directly to you and you may be responsible for any balance remaining. If you have assigned benefits under this

plan to your doctor according to Medicare guidelines, we will pay benefits under this plan directly to your doctor, as required. In all other cases where benefits are payable to you, such payments shall not be assignable without our written approval.

## **SUBROGATION AND RIGHT OF REIMBURSEMENT:**

When we pay a claim, we are subrogated to all rights you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of BCBSD's rights include:

- **Constructive trust.** Accepting benefits from BCBSD makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until BCBSD receives payment. Failure to pay funds to BCBSD will be considered a breach of your duty to the health care plan. No settlement can be made without BCBSD's written permission.
- **Subrogation lien.** Accepting benefits from BCBSD will result in an automatic lien by BCBSD against any recovery from any third party. This means BCBSD has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that BCBSD has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. BCBSD is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** BCBSD is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying BCBSD.** If you are involved in an accident or incident that results in both BCBSD paying a claim and you having a claim against any third party, you must notify BCBSD in writing within 30 days.
- **Cooperating with BCBSD.** You are required to cooperate with BCBSD and assist in the recovery from the third party.

## **LEGAL ACTION**

No legal action may be brought against us for failure to provide benefits under this plan unless brought within 3 years from the date the service in question was rendered.

## **CANCELLATION FOR MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACTS**

We may cancel this plan at any time if we learn:

- That the statements you made at the time you applied for coverage were untrue or incomplete; or

- That you received or attempted to receive benefits under this plan under circumstances indicating fraud or other intentional misconduct; or
- You assisted another person as specified above.

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## HOW BCBSD PROTECTS YOUR CONFIDENTIAL INFORMATION

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It is necessary for BCBSD to receive information about you and your health to properly administer your plan benefits. This information is called "Personal Identifiable Health Information" and includes items such as your

- provider's name,
- tests that were done,
- diagnosis, or
- costs of treatment.

The following explains how BCBSD protects the confidentiality of your Personal Identifiable Health Information.

### YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

By enrolling with BCBSD, you agree that we can receive information from your providers about care that you received. You also permit BCBSD to release your Personal Identifiable Health Information to business associates outside BCBSD, such as

- organizations that process claims,
- people who help coordinate services, or
- auditors.

We may need to release your Personal Identifiable Health Information to:

- process and pay claims,
- coordinate benefits when you're covered under another health plan,
- monitor care,
- help manage a chronic illness, such as diabetes or congestive heart failure,
- measure satisfaction through customer surveys, or
- conduct studies to measure our performance and our providers' performance.

In situations other than our routine business practice, BCBSD will only release Personal Identifiable Health Information if you sign the *Notice of Specific Consent* form. The form will contain information such as what is being released, who is getting the information and why the information is needed.

### WITHDRAWING CONSENT

If you signed a *Notice of Specific Consent* form, you may withdraw that consent by calling or writing BCBSD's Customer Service Department. When you call, please specify which information indicated on the *Notice of Specific Consent* form you don't want released. However, if you withdraw that consent, the withdrawal will not affect any Personal Identifiable Health Information that BCBSD has already released based on your signing the *Notice of Specific Consent* form.

### SHARING YOUR INFORMATION WITH YOUR EMPLOYER

At times it may be necessary for BCBSD to provide your employer with information such as

- medical cost experience
- claims volume
- cost savings.

This information helps your employer and BCBSD to determine future premium rates. This information is also used to monitor BCBSD's performance.

We do not release your Personal Identifiable Health Information to your employer without your signing a *Notice of Specific Consent* form, unless we are required to do so by law. The consent form will contain information such as what is being released, who is getting the information and why the information is needed.

## **YOUR RIGHT TO ACCESS MEDICAL RECORDS**

You have the right to access the medical records that were originated by BCBSD. Some examples of such records are the *Explanation of Benefits* and authorization of service forms. You can request your records by either writing or calling BCBSD's Customer Service Department.

## **HOW BCBSD PROTECTS YOUR PRIVACY**

All BCBSD Employees are required to sign confidentiality statements when they're hired. Employees are then trained to follow certain guidelines to protect your confidential information. However, employees need to discuss your information with other employees when performing routine business practices, such as when they

- process claims,
- resolve disputes,
- answer inquiries, or
- coordinate care or benefits.

Much of your Personal Identifiable Health Information is on our computer network. Our employees are granted access to the network only on a need-to-know basis. BCBSD's management determines the level of access that employees need to perform their job. Our systems are password protected. Passwords are periodically changed to prevent unauthorized access.

BCBSD also requires that your providers follow confidentiality policies. We periodically audit providers to ensure that your medical records are kept private and that their staff has received confidentiality training.

## **USE OF MEASUREMENT DATA**

We conduct surveys and health studies to measure customer satisfaction to help us improve our services. Health studies help us measure our performance and our providers' performance. Information collected during these studies is reported for the entire group rather than for one person. Your Personal Identifiable Health Information is not identified.

BCBSD sometimes uses outside agencies to conduct surveys and studies. BCBSD requires these agencies to sign a confidentiality agreement and to train their employees about confidentiality.

## **COMPLAINTS AND QUESTIONS**

You have the right to file a complaint with us at anytime you feel that we have not maintained your privacy. You also have the right to ask questions about our confidential policy. To do either, please call BCBSD's Customer Service Department at:

Local Calls: 429-0260  
Long Distance Calls: 1-800-633-2563

## **SUGGESTIONS AND COMPLAINTS**

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BCBSD welcomes questions, suggestions, and complaints. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about BCBSD's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

So that we can learn about our panel providers, you may also call or write us when you have a concern about:

- access to your PCP or other provider
- the care you received

### **BCBSD's Address**

Customer Service  
Blue Cross Blue Shield of Delaware  
P.O. Box 8799  
Wilmington, DE 19899-8799

### **BCBSD's Customer Service Telephone Numbers**

Local Calls: 429-0260  
Long Distance Calls: (800) 633-2563

### **BCBSD's Internet Address:**

[www.bcbsde.com](http://www.bcbsde.com)

To learn how to appeal benefits, see "Benefits Appeal" in the section, *A Guide to Claims*.



## DEFINITIONS

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**Accident** means accidental bodily injury that is sustained as the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this plan is in force.

**Admission** means the period from the time you enter a hospital or skilled nursing facility as an inpatient until discharge.

**Allowable Charge** means the fee or price Blue Cross and Blue Shield of Delaware determines to be reasonable for services and supplies.

**Benefit Period** means the period beginning with the first day of admission to a hospital or Skilled Nursing Facility and ending when you have gone 60 consecutive days without admission to either a hospital or Skilled Nursing Facility.

**BCBSD** means Blue Cross Blue Shield of Delaware.

**Coinsurance** means the portion of covered charges for services that, under Medicare, is your responsibility to pay. The coinsurance is the amount remaining after Medicare payment is made.

**Deductible** means a portion of covered charges for services which is payable before Medicare begins paying. The deductible amount is determined by Medicare.

**Durable Medical Equipment** means medically necessary equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces used only during an illness or injury. It does not include disposable items.

**Explanation of Benefits (EOB):** A written statement issued to a member that provides detail concerning processing and payment of a claim for benefits, including the member's financial responsibility for services rendered.

**Hospital** means any institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and which operates pursuant to state law and which provides diagnostic and therapeutic facilities for services performed mostly on an inpatient basis. Such services must at a minimum include: surgical and medical diagnosis and treatment; and twenty-four hour a day nursing service under the direction or supervision of registered professional nurses. Hospital services must be supervised and rendered by a staff of physicians.

**Inpatient** means a person admitted to a hospital or skilled nursing facility for an overnight stay.

**Licensed Practical Nurse** means a person licensed as such by the state in which they practice nursing.

**Medically Necessary** means those services or supplies which are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by us, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for your convenience, the doctor's convenience, or any other provider's convenience; and,
- The most appropriate supply or level of service that can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare includes Part A Hospital Insurance Benefits; Part B Supplementary Medical Benefits; and includes rules, regulations, directives and interpretations about these programs issued by the Secretary of Health and Human Services.

**Medicare Eligible Expenses** means the health care expenses of the kinds covered by Medicare and to the extent recognized as reasonable by Medicare.

**Mental and Nervous Disorders** means emotional and personality illnesses as classified by the International Classification of Diseases. Excluded are psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation or illnesses determined by us as not amenable to favorable modification.

**Outpatient** means a person who is receiving services or supplies while not an inpatient in a hospital or skilled nursing facility.

**Physician or Doctor** means any person who is licensed to practice medicine and surgery, osteopathy, podiatry, chiropractic or dentistry and who is acting within the scope of that license.

**Prescription Drugs** means a substance which is used in the cure, treatment, or prevention of a disease or illness which can only be obtained upon a physician's prescription; and which BCBSD has approved as prescription drugs.

**Reasonable Charge** means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.

**Registered Professional Nurse** means a person licensed as such by the state in which he or she practices nursing.

**Resource Based Relative Value Scale** – a schedule established by the federal government to standardize physician payments as determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, each of which is resource-based. Payments are adjusted for geographical differences in resource costs.

**Skilled Nursing Facility** means extended care facilities, convalescent hospitals or rehabilitation centers providing skilled nursing care or rehabilitation services and approved by Medicare. Medicare's approval is based on the facility's guarantee of safety to the patient and effectiveness of the care rendered to the patients. These facilities provide:

- Skilled nursing and related services on an inpatient basis for patients who require continuous, 24 hour a day medical or nursing care.
- Rehabilitation for patients who require such care because of illness, disability or injury.

**We, Us or Our** refers to Blue Cross Blue Shield of Delaware.

**You and Your** refers to the employee or any eligible dependents you have enrolled for coverage. You must be eligible for enrollment in the Medicare program and enter into agreement with us for supplementary coverage.





**State of DE Special Medicfill**  
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